CNA HealthPro

Improving Documentation Through Self-Assessment

While most dentists readily admit that their recordkeeping practices could be improved, they also admit that they are often too pressed for time to write as much as they should. One aspect of managing risk is to recognize those instances when additional measures are warranted. In the realm of documentation, this means writing more comprehensive entries for those patients and clinical procedures that you believe present a heightened risk. The risk may be an adverse outcome or simply patient dissatisfaction. Both of these matters may trigger dental professional liability claims.

Accurate and thorough records are one of your most powerful risk management tools and a foundation of quality patient care. Comprehensive, thorough documentation reduces the opportunity for treatment errors, communication problems and patient dissatisfaction.

The dental record serves two major purposes. It preserves your memory about important patient information and facilitates the sharing of vital information, both within and outside your practice. All information critical to continued patient care should be documented in the patient record.

In the event that you do become a defendant in a malpractice action, a comprehensive dental record is your major defense weapon. Juries in malpractice trials are informed routinely that the dentist is expected to record all important clinical and non-clinical patient information. It is difficult for a plaintiff to challenge an accurate and unaltered dental record written at the time of treatment. Conversely, a deficient dental record is very difficult for the defense to support, even with the best oral testimony from the dentist and staff.

Responding to a series of probing questions is one method you and your staff may use to evaluate the quality of your recordkeeping. Recognizing your vulnerability to a malpractice claim or to a weak defense should a non-meritorious claim arise is the first step toward reducing the likelihood and severity of malpractice claims. The self-evaluative method of recognizing your deficiencies can be effective in helping you enhance the quality of your practice's documentation.

How to use the assessment tool

On the following pages, you will find a self-assessment checklist pertaining to various aspects of record keeping. For each query, determine if you and your staff practice the questioned technique

- Always
- Usually
- Occasionally
- Never

The more times you can answer *always* or *usually*, the better your documentation will continue to be. Those that you answer *occasionally* or *never* should be evaluated for a fuller incorporation into your day-to-day routine.

Keep in mind that this assessment tool does not encompass every possible documentation issue. Additionally, you may find that you use a technique that achieves the same result via a different method.

The purpose of using this self-assessment tool is for each practice to validate the good recordkeeping practices already employed and to more easily identify areas where documentation can be improved.